Does Sgt Pearson Have PTSD?

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When I first met Sgt Pearson at a Starbucks in the army town of Fayetteville, North Carolina, in 2012, he ordered a latte with soy milk.[1] At age 29, with ten years of military service and four tours of duty in Iraq and Afghanistan behind him, he is what infantrymen sometimes call a "war dog," a seasoned soldier. In addition to lactose intolerance – a condition he blames on drinking long life army milk – he's got 70 percent hearing loss, stress fractures in his feet, and a mostly healed broken shoulder. After work he has to lie down for an hour "just to be able to do anything." He is worried by the prospect of being away from his seven year old son during an impending deployment to Afghanistan. He's got "a bit" of agoraphobia, a lot of insomnia, and he said, "nightmares." Then he added thoughtfully: "Not really nightmares because they aren't fictional, just memory replaying."

Does Sgt Pearson also have PTSD, an acronym that has become so widely known that in many countries it is not necessary to write it out? The American Psychiatric Association introduced the term post-traumatic stress disorder in 1980. It has a range of symptoms, including notably the flashbacks or "memory replaying" that Sgt Pearson mentioned, as well as avoidance and hyperarousal. Though PTSD is also diagnosed in civilians, it has become the most significant mental health problem in combat veterans in the West. It is estimated that around a fifth of the two million American veterans of Iraq and Afghanistan have PTSD. But it is not known how many ultimately will get the disorder since symptoms can develop months or years after exposure to a traumatic event.

When I met Sgt Pearson again in 2013, he had just returned from Afghanistan – his fifth tour of duty. He told me had been ordered to have a "PTSD test" by a superior but had not yet done so. The outcome of that test, if he ever gets it, could have major consequences. A "service-connected" diagnosis of PTSD – a category that recognizes that illness resulted from military service – can confer a substantial disability pension. The US Veterans Affairs Administration (VA) spent around 36 billion dollars on disability compensation in 2010. Yet despite the potential benefits a PTSD diagnosis confers to veterans, many active duty soldiers fear that it would land them a despised job as what Sgt Pearson calls a "desk jockey" or end their career.

In this section, I reflect on what happened before that "PTSD test" – why he was ordered to have it and why he did not want to follow this order. I draw on pilot anthropological fieldwork with soldiers who have been in combat and are now stationed back home. I explore soldiers' perspectives on the military and healthcare institutions that play an important part in their lives post-deployment, and how they come to accept – or reject – clinical interpretations of their problems.

Given all that is at stake with PTSD, not surprisingly the disorder has sparked major controversy. One issue is its prevalence. Humanitarian responses to war and disaster in the developing world now often include mental health services to prevent or treat PTSD. Derek Summerfield (1999:1460) has argued that such efforts make disaster into a "mental health emergency writ large" and can weaken collective forms of coping and healing.[2] Others decry the widening range of people being diagnosed with PTSD: victims, perpetrators, and witnesses of violence as well as those who give care to the traumatized and even those who observe traumatic events in the media.

Fassin and Rechtman (2009) counter that the PTSD illness concept is not "good" or "bad" in itself, but reflects an altered moral attitude towards the ill or injured person that goes beyond clinical issues. They argue that previously those who suffered from medically unexplained symptoms caused by violence or accident were often suspected of malingering, or else of unconsciously seeking "secondary gain"(i.e. the benefits that can be gained through illness, such as sympathy, care or disability pensions.) The PTSD concept in a sense "exonerates" the ill person and shifts the "blame" for illness onto an external event. As a result of the social and material benefits that can follow from its diagnosis, PTSD is -- in Rechtman's words -- the only kind of psychological disorder "you want to have" (2004: 914).

However, like many active duty soldiers in the US military, Sgt Pearson did not seem to "want" this diagnosis. Criticism of the over-diagnosis of PTSD has largely focused on civilians or veterans who have left military service. The moral significance and material effects of a PTSD diagnosis are often quite different for soldiers still in the military. In the American army, there has been rising concern that soldiers with PTSD are not getting expert help. Some studies have found that less than a quarter of soldiers who are "positive for a mental disorder" (as determined by an anonymous survey) ever see a provider (Hoge et al. 2004). Suicide rates have been rising, and outpaced combat deaths for the first time in 2012. In response, clinicians and military leaders have launched major suicide research studies and an ambitious resilience training program. They have also conducted quantitative studies of "barriers to care" that seek to understand why so few soldiers seek mental health treatments. One study that found that "negative attitudes towards treatment inversely predict treatment seeking" and concluded, logically enough, that policy should aim "at reducing negative attitudes toward mental health treatment" (Kim et al. 2011:65)

Ethnographic research can complement such quantitative research by exploring how such negative attitudes are generated or sustained by daily life and institutions. Sgt Pearson has to date never received a mental health diagnosis, but was admitted into an alcohol abuse program some years ago: "Someone in the 25th in Hawaii decided all these guys just needed counselors. So we would meet in a coffee house, or for lunch, like here." Today he says he only has one to two drinks a day – but then scoffs that this is the army's "official definition of an alcoholic." He was given antidepressants by an army doctor, but stopped taking them as they made him feel worse, and had "male" side effects. He also saw a social worker "around three times" after his first deployment. He said "she was educated in talking to people, but we had no common experiences." He added, **"**Things you did there would be unforgiveable here. That weighed on me. I went to talk to a Baptist preacher back home. He was a Vietnam vet." He was also ordered to see a psychologist in Afghanistan, but he stopped seeing him after a couple of sessions. And most recently he received that command referral to get a "PTSD test."

It is not entirely clear whether Sgt Pearson has ever voluntarily sought or even received mental health care. While he did *choose* to see the social worker, preacher, and GP, he was *ordered* to see the psychologist and to have the PTSD test. This mix of choice and coercion in a therapeutic trajectory that took him from medical to psychotherapeutic to pastoral care makes it hard to determine whether he encountered a barrier to mental health care. Recently, the military has tried to de-stigmatize PTSD, partly to make it unnecessary to order soldiers such as Sgt Pearson to see a clinician. For example,

military leaders have been using new language to discuss mental health – or what is often now called "behavioral health." Some clinicians have dropped the D from PTSD since "disorder" sounds more serious than "stress." Others refer to PTSD an "injury" to emphasize that it was honorably earned during combat.

Sgt Pearson seemed aware of such efforts but was skeptical: "It's like there are two levels [of leadership]. At the higher level there is the liberal voice of the army that says meet up, help each other. It cares about high suicide rates. They started treating PTSD as if you're, like, a rape victim, using the same treatment. Hopefully it works. But then on the lower level [of the army] PTSD is really stigmatized."

The soldiers I spoke to mostly belonged to this "lower level": enlisted men, NCOs, and a few lower ranking officers. This group – while by no means representative of the enormously diverse army – might seem to hold precisely those "negative attitudes" identified by the quantitative research mentioned earlier. It was not that PTSD was a taboo topic for them; it came up frequently in conversation and often in a joking manner. But more serious talk about PTSD often mentioned soldiers "who get paid for PTSD." Sgt Pearson said: "These guys on the big bases, who never saw combat and did paperwork. Some of these guys get paid for PTSD. It really bothers me. Some guys I knew I had to stop talking to them, people who faked PTSD." Other soldiers went further, claiming that *anyone* who "got paid for PTSD" didn't really have it. Although several soldiers openly talked about having some of the symptoms that have now become recognizable signs of PTSD in American popular culture – such as hitting the floor in response to a sudden noise – they thought that most of their comrades who "get paid for PTSD" do not really have the disorder.

The comments of Sgt Pearson and his comrades might conceivably be changed by training and education programs. Yet, I think these soldiers are not uninformed about mental health problems. Rather they also possess some insight into the current institutional and moral climate in which PTSD is diagnosed and lived.

While Sgt Pearson did have a few contacts with caregivers, he was largely unhappy with what happened: "Army doctors are biased. If you start saying anything [about a work dispute], they might side with your commander." Civilian norms around patient confidentiality often do not apply to soldiers. For example, a clinician may be obligated to reveal information about clients to their commanding officers. Of course patient confidentiality is never an "absolute" right and the limits to that right in the military are based partly on common sense concerns around giving weapons to someone with a disorder or who is on medication. Yet military clinicians sometimes have fundamentally competing obligations: to heal patients and to support military operations.

It has been said that the "true patient" of the military psychiatrist is the army itself. This professional position can create major ethical dilemmas. During World War I a psychiatrist who found a case of war neurosis to be false might send his patient back to the front. Today a soldier judged to have "fake PTSD" would not be sent to a war zone; more likely, steps would be taken to *remove* him from a war zone. Yet the clinician still has unusual power over the soldier-client. "Withholding" a service-connected diagnosis of PTSD can deny a soldier disability benefits. The high moral and material stakes of PTSD were made evident in recent scandals about the "downgrading" of PTSD to a pre-existing condition such as a personality disorder. As Kenneth Macleish (2013:127) points out, questions about overdiagnosis are inevitably bound up with the enormous

economic stakes of disability compensation as well as the "weightier moral economy of who bears responsibility for the effects of violence." Many active duty soldiers are simply concerned that a diagnosis of PTSD can harm their career and status as a good soldier who stoically sucks up pain and suffering.

Capt Mulhern said: "Like anyone who has seen a lot of combat, I have a little bit of PTSD." What is a little bit of PTSD? In epidemiology, clinical trials and disability assessments, disorders are present or absent; they must be counted. Of course there are more or less severe cases. But what Capt Mulhern meant I think was *not* that he had a mild case of PTSD. Rather, he seemed to be getting at ambiguity in the PTSD concept itself. This captain – who seemed to be highly respected by his subordinates -- did not see his symptoms as evidence of mental disorder but rather as evidence of being a good soldier. Symptoms such as a violent temper or jumpiness or a tendency to brood were testimony to having served in combat. They reflected an unspoken sentiment that has perhaps taken root in the US since the Vietnam War: combat messes you up a bit. After war it is normal to be a bit abnormal. What defined PTSD qua mental health disorder for these soldiers was not the presence or absence of PTSD symptoms, but rather the official diagnosis and, paradoxically, the disability pension that might come in its wake.

The logic for them seemed to go something like this. Real soldiers – those who've been in combat -- have PTSD symptoms by virtue of being real soldiers. But real soldiers don't get *diagnosed* with the disorder because they know that such symptoms are one of many risks of the job. And those who are diagnosed with PTSD cannot be real soldiers because they violate a soldierly ethos by seeking benefits for simply doing what they're paid to do.

This reasoning about illness and malingering was different from that used by clinicians. For clinicians, illness stigma and malingering are problems that are "external" to the illness itself. Stigma prevents the person who truly has PTSD from getting treatment or benefits they deserve. Malingering is a related, but almost inverse problem. Soldiers who fake or exaggerate symptoms, one neuropsychologist told me, hinder his ability to properly measure clinical outcomes, a problem he resolves by administering effort tests to patients. This position of clinicians – logical as it is -- is different from that of soldiers who speak with what Sgt Pearson called the second voice of the army. For these soldiers symptoms are less important than the issue of disability pension. It seems they could not, or would not, divest PTSD of its material and moral significance. Their attitude echoes the generally suspicious stance taken by military clinicians themselves towards soldiers in earlier eras when the discipline was heavily influenced by psychoanalysis and its concept of secondary gain.

Sgt Pearson said he had done "unforgiveable things there." Later he mentioned one incident in Iraq, when he had mistakenly killed civilians by firing a grenade launcher at a farmhouse he thought was occupied by insurgents. He explained, "Killing does affect you. If it doesn't affect you then you are a sociopath. I mean it doesn't affect some people that much, but if it doesn't affect you at all then you're a sociopath."

What he seems to say here is that it is normal for killing to affect you, so why should those affected by killing be seen as mentally ill? Isn't the soldier who is *not* affected at all by killing the one who is ill, a "sociopath"? These questions are perhaps one reason why he remains ambivalent about clinical care. The clinical encounter can seem to exclude the moral significance of violence – who did what to whom and whether

it was justified, honorable, courageous, wrong, or cruel? In some forms of psychotherapy, a goal is to process emotions such as guilt. Yet the therapeutic attitude – it's OK: I sympathize with you now as a suffering patient with a right to heal – might seem to some soldiers to fly in the face of what they know, which is that at least some of what happened was terribly wrong.

Paradoxically, the reverse kind of moral dissonance can also happen in treatment: what was normal during combat becomes immoral when confessed to a clinician. Either way, the difference in how violence is morally valued in clinical as opposed to military situations may contribute to the pervasive feeling among soldiers that "you can't understand if you weren't there." It might also be one reason Sgt Pearson preferred to talk with a Baptist preacher who was a Vietnam veteran than with a social worker.

I don't know if Sgt Pearson has PTSD and he probably didn't either the last time I spoke with him. He seemed open to the possibility yet also deeply skeptical: "I can function. I'm truly not sure if I have it. I have changed over the years, but I'm not sure it's PTSD. I don't want to be on meds. I'm not interested in taking a pill because the Army tells me I need to function."

What might appear to be a negative attitude on his part perhaps indicates his uncertainty as to whether the clinician's "true patient" would be himself -- or the army. But Sgt Pearson seems to also have a kind of disquiet, a more fundamental doubt as to whether intense stress, killing, seeing others die -- and other horrors that he views as a normal part of the job – could actually make him ill in the first place.

Sgt. Pearson's experiences are not easily encompassed by the diagnosis of PTSD. And why should they be? No one's life can be reduced to a mental illness category. But PTSD is currently made to do a lot of explanatory "work." It can explain why a soldier is having life problems, but explain *away* bad behavior such as stony silence around loved ones. It can determine entitlements to disability pensions, or end a valued career as a professional soldier. It can signify the heroism of self-sacrifice, or the horrors of combat, or simply weakness.

Yet the PTSD diagnosis also leaves unexplained questions that most plague Sgt. Pearson. "Why are (some of) my comrades ill or homeless, and I'm functioning when we both had the same experiences? Isn't it after all normal to feel this way after all I've been through?" And at moments when he is prone to darker thoughts about the war, he also wonders simply "why am I alive and (some of) my enemies and comrades dead?"

Perhaps Sgt Pearson has a borderline case. He has some symptoms, but he also functions. Ultimately, whether he has PTSD will be determined not only by past violent events, but by the interpretation of affliction, including his own interpretation. As he moves through different military and healthcare environments these interpretations will change – and bring new consequences. One task of the anthropologist is to study such a journey: to try to understand what the PTSD description means and what it does for people differently situated in the world.

References

Fassin, Didier and Richard Rechtman. *The Empire of Trauma: An Inquiry into the Condition of Victimhood.* Princeton, NJ: Princeton University Press, 2009.

Hoge, Charles, et al. Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine* (2004) 351:1,13-22.

Kim, Paul et al. Stigma, Negative Attitudes about Treatment, and Utilization of Mental Health Care among Soldiers. *Military Psychology* (2011) 23:65-81.

Finley, Erin. *Fields of combat: Understanding PTSD among veterans of Iraq and Afghanistan.* Ithaca, NY: Cornell University Press, 2011.

Macleish, Kenneth. *Making War at Fort Hood: Life and Uncertainty in a Military Community.* Princeton, NJ: Princeton University Press, 2013.

Summerfield, Derek. A Critique of Seven Assumptions behind Psychological Trauma Programmes in War-Affected Areas. *Social Science & Medicine* 48 (1999):1449-1462.

Rechtman, Richard. The Rebirth of PTSD: The Rise of a New Paradigm in Psychiatry. *Social Psychiatry and Psychiatric Epidemiology* (2004) 39:913-915.

Wool, Zoe. On Movement: The Matter of Soldiers' Being After Combat. *Ethnos* (2013) 78(3)

Young, Allan. *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*. Princeton, NJ: Princeton University Press, 1997.

Endnotes

[1] I use pseudonyms in this article. I draw on pilot fieldwork conducted in Fayetteville, North Carolina. This research is part of a multi-country study of soldiers' reintegration and psychological wellbeing and health after combat, which is funded by the European Research Council.

[2] There is also a growing anthropological literature on PTSD and soldiers' combat experiences. See Macleish (2013), and Wool (2012) for excellent ethnographies of U.S. soldiers' bodily experiences, and Finley's (2009) nuanced analysis of PTSD among veterans in the VA system. Allan Young's (1997) now classic work critically discusses the notion of traumatic memory at the core of PTSD.